	HealthSelect	hSelect CIGNA				
		A. HMO			C. PPO	
	In-Network	In-Network	In-Network	Out-of Network	In-Network	Out-of Network
Standard Benefit Coverage						
Deductible						
Individual	None	None	None	\$300	\$250	\$750
Family	None	None	None	\$600	\$500	\$1,500
Standard Coinsurance Percentage Covered by Plan		100%	100%	70% after deductible	80% after deductible	60% after deductible
Out of Pocket Maximum for specific services						
Individual		\$1,000 OOP Max	\$1,000 OOP Max	\$3,000 OOP Max	\$2,000 OOP Max	\$4,000 OOP Max
Family		\$2,000 OOP Max	\$2,000 OOP Max	\$6,000 OOP Max	\$6,000 OOP Max	\$12,000 OOP Max
Lifetime Maximum Benefit		Unlimited	Unlimited	\$5,000,000	Unlimited	\$5,000,000
				12 Months Waiting Period (18	12 Monts Waiting period (18	12 Months Waiting period (18
				months late entrant), waived if	months late entrant), waived if	months late entrant), waived if
Pre-existing Conditions	None	None	None	covered 1/01/03	covered 1/1/03	covered 1/01/03
General Services						
Preventive Care	\$5 Copay	\$10 Copay	\$15 Copay	Covered In-Network Only	\$20 Copay	Covered In-Network Only
Primary Care Physician Services	\$5 Copay	\$10 Copay	\$15 Copay	70% after deductible	\$20 Copay	60% after deductible
Specialty Care Physician Services	\$5 Copay	\$10 Copay	\$25 Copay	70% after deductible	\$30 Copay	60% after deductible
Urgent Care Facility (Participating)	\$5 Copay	\$35 Copay	\$50 Copay	70% after deductible	\$50 Copay	60% after deductible
3 , (1 3)		No Copay for lab or X-Ray	No Copay for lab or X-Ray			
Out-patient Lab and X-Ray	No Copay	\$50 Copay for MRI & CAT	\$50 Copay for MRI & CAT	70% after deductible	80% after deductible	60% after deductible
In-patient Coverage						
			\$100 Copay (reimbursed by	70% (Precertification		60% (Precertification
Facility Charges	No Copay	No Copay	County)	Required)* after deductible	80% after deductible	Required)* after deductible
				70% (Precertification		60% (Precertification
Physician & Surgeon's Services	No Copay	No Copay	No Copay	Required)* after deductible	80% after deductible	Required)* after deductible
Outrations Comment	No Commit	No Consu	¢50 Canav	70% (Precertification Required)* after deductible	200/ often deductible	60% (Precertification
Outpatient Surgery	No Copay NA	No Copay NA	\$50 Copay NA		80% after deductible	Required)* after deductible
Non-certification Penalty	NA NA	NA NA	INA	\$400 Penalty	\$400 Penalty	\$400 Penalty
Maternity						
Pre & Postnatal Exams(after pregnancy has been determined)	Copay waived after 1st visit	Copay waived after 1st visit	Copay waived after 1st visit	70% after deductible	Copay waived after 1st visit	60% after deductible
determined)	Copay waived after 13t visit	Copay waived after 13t visit	\$100 In-Patient Copay	7070 arter deductible	Copay waived after 13t visit	00% after deddetible
Delivery	No Copay	No Copay	(reimbursed by County)	70% after deductible	80% after deductible	60% after deductible
Emergency Care (Defined by Plan)	, ,	• •	, , , , , , , , , , , , , , , , , , , ,			
				\$100 Copay if emergency,		\$100 Copay if emergency,
Emergency Room-Copay Waived @ Admit	\$50 Copay	\$75 Copay	\$100 Copay	otherwise 70%	\$100 Copay	otherwise 60%
Ambulance	No Copay	No Copay	No Copay	No Copay	90% after deductible	90% after deductible
Equipment & Devices						
Durable Medical Equipment	No Copay	No Copay (\$3500 Max)	No Copay (\$3500 Max)	Covered In-Network Only	80% after ded. (\$700 max.)	60% (\$700 max.)
Let a see	' '		, , , , , , , , , , , , , , , , , , , ,	,	80% after \$200 ded. (\$1,000	60% after \$200 ded, (\$1000
External Prosthetics & Orthotics	No Copay	No Copay (\$1000 Max)	No Copay (\$1000 Max)	Covered In-Network Only	max.)	max.)
Outpatient Rehabilitation						
Physical, Speech, and Occupational						
Therapy	\$5 Copay	\$10 Copay	\$10 Copay	70% after deductible	\$20 Copay*	60% after deductible*
Chiropractic Services						
Open Access; No referral required; visit limit is per	\$10 Copay	\$10 Copay	\$10 Copay		\$20 Copay**	60% after deductible**
calendar year	12 Visits	20 visits	20 Visits	Covered In-Network Only		
			*60 therapy visits, in-network & out-of-network co		out-of-network combined	
Benefit Limit per calendar year	60 Visits/Days	60 visits combined	60 visits, in-network & out-of-network combined **Unlimited chiropractic visits			

Ancillary Benefits						
Vision & Hearing Screening	\$5 Copay, \$500 per year	\$10 Copay	\$15 Copay	Covered In-Network Only	\$20 Copay	Covered In-Network Only
Other Healthcare Facilities	φ3 Copay, φ300 per year	фто Сорау	ф то сорау	Covered in Network City	φ20 σοραγ	Covered in Network City
Skilled Nursing Facilities						
	No Consu	No Copay	No Copay	70% after deductible	80%	60%
Subscriber Payment	No Copay	' '				
Limit per Contract Year	20 days per illness	90 Days Combined No Copay when medically	90 Days Combined No Copay when medically	90 Days Combined	90 Days Combined 80% after deductible	90 Days Combined
Home Health Care	No Copay when medically necessary (Unlimited)	necessary (Unlimited)	necessary (Unlimited)	70% ded. up to 40 Days per Year	(Unlimited)	60% after ded. up to 40 Days per Year
	flecessary (Offilifflited)	necessary (Orininited)	riecessary (Oriminited)	real	(Offilifilited)	регтеаг
Family Planning						
Sterilization			5. (0.)			
Vasectomy	Place of Service Copay	Place of Service Copay	Place of Service Copay	70% after deductible	80% after deductible	60% after deductible
Tubal Ligation	Place of Service Copay	Place of Service Copay	Place of Service Copay	70% after deductible	80% after deductible	60% after deductible
		Diagnostic Services and	Diagnostic Services and		Diagnostic Services and	
Infertility Treatment	Not Covered	Corrective Treatment Only	Corrective Treatment Only	Covered In-Network Only	Corrective Treatment Only	Covered In-Network Only
Dependent Children						
	Covered to Age 19 Unless Full	Covered to Age 19 Unless Full	Covered to Age 19 Unless Full Time Student and Then		Covered to Age 19 Unless Full Time Student and Then	
Unmarried and legally dependant upon employee	Time Student and Then	Time Student and Then Covered				
and/or spouse	Covered to Age 25	to Age 25	Covered to Age 25		Covered to Age 25	
Pharmacy Benefit	HealthSelect	Walgreens Health Initiatives	Walgreens Health Initiatives		Walgreens Health Initiatives	
	RETAIL 30-day supply	RETAIL 30-day supply	RETAIL 30-day supply Tier 1 Generics:		RETAIL 30-day supply	
	\$5.00 Copay for Generics	Tier 1 Generics:			Tier 1 Generics:	
	\$15.00 Copay for Brand	25% Coinsurance; Max \$10	25% Coinsurance; Max \$10		25% Coinsurance; Max \$10	
	MAIL ORDER 90-day supply	Tier 2 Brand (Preferred):	Tier 2 Brand (Preferred):		Tier 2 Brand (Preferred):	
	\$15 Copay for Generics	30% Coinsurance; Max \$25	30% Coinsurance: Max \$25		30% Coinsurance; Max \$25	
	\$30 Copay for Brand	Tier 3 Brand (Non-Preferred):	Tier 3 Brand (Non-Preferred):		Tier 3 Brand (Non-Preferred):	
		30% Coinsurance; Max \$50	30% Coinsurance; Max \$50 MAIL ORDER 90-day supply Tier 1 Generics; 20% Coinsurance; Max \$28		30% Coinsurance; Max \$50	
		MAIL ORDER 90-day supply			MAIL ORDER 90-day supply	
		Tier 1 Generics; 20%			Tier 1 Generics; 20% Coinsurance; Max \$28	
		Coinsurance; Max \$28				
		Tier 2 Brand (Preferred); 25%				
		Coinsurance; Max \$70	Tier 2 Brand (Preferred); 2	25% Coinsurance; Max \$70	Tier 2 Brand (Preferred); 2	25% Coinsurance; Max \$70
		Tier 3 Brand (Non-Preferred);		·		
		25% coinsurance; Max \$140	Tier 3 Brand (Non-Preferred); 25% coinsurance; Max \$140 Annual Out-of-Pocket Maximum \$1500 Single/\$3,000 Family		Tier 3 Brand (Non-Preferred); 25% coinsurance; Max \$140	
		Annual Out-of-Pocket Maximum			Annual Out-of-Pocket Maximum	
		\$1500 Single/\$3,000 Family			\$1500 Single/\$3,000 Family	
Behavioral Health Benefit	United Behavioral Health	United Behavioral Health	United Behavioral Health		United Behavioral Health	
Vision Benefit	AVESIS Vision Plan	AVESIS Vision Plan	AVESIS Vision Plan		AVESIS Vision Plan	
Note: Lifetime Maximum and Visits per year for	Out of Network Services, cros	s-accumulates with In-Network.				
The plan documents under links on the Benefits Ho	ome page provide a complete des	cription of benefits. These official d	ocuments govern if there is a dis	screpancy between the information	on on this comparison.	
Revised 01/14/03	T:/Benefits/Knowyourbenefits/M	/orking/plandesigns011403.xls	-		·	
		-				

	A. HMO	B. POS	B. POS	C. PPO	C. PPO
Other land Devertit Oncome	<u>In-Network</u>	In-Network	Out-of Network	<u>In-Network</u>	Out-of Network
Standard Benefit Coverage					
Deductible			*	0050	0750
Individual	None	None	\$300	\$250	\$750
Family	None	None	\$600	\$500	\$1,500
Standard Coinsurance Percentage Covered by Plan Out of Pocket Maximum for specific services	100%	100%	70% after deductible	80% after deductible	60% after deductible
Individual	\$1,000 OOP Max	\$1,000 OOP Max	\$3,000 OOP Max	\$2,000 OOP Max	\$4,000 OOP Max
Family	\$2,000 OOP Max	\$2,000 OOP Max	\$6,000 OOP Max	\$6,000 OOP Max	\$12,000 OOP Max
Lifetime Maximum Benefit	Unlimited	Unlimited	\$5,000,000	Unlimited	\$5,000,000
			12 Months Waiting Period (18 months late entrant), waived if	,,	12 Months Waiting period (18 months late entrant), waived if
Pre-existing Conditions	None	None	covered 1/01/03	covered 1/1/03	covered 1/01/03
General Services					
Preventive Care	\$10 Copay	\$15 Copay	Covered In-Network Only	\$20 Copay	Covered In-Network Only
Primary Care Physician Services	\$10 Copay	\$15 Copay	70% after deductible	\$20 Copay	60% after deductible
Specialty Care Physician Services	\$10 Copay	\$25 Copay	70% after deductible	\$30 Copay	60% after deductible
Urgent Care Facility (Participating)	\$35 Copay	\$50 Copay	70% after deductible	\$50 Copay	60% after deductible
	No Copay for lab or X-Ray	No Copay for lab or X-Ray			
Out-patient Lab and X-Ray	\$50 Copay for MRI & CAT	\$50 Copay for MRI & CAT	70% after deductible	80% after deductible	60% after deductible
In-patient Coverage					
		\$100 Copay (reimbursed by	70% (Precertification		60% (Precertification
Facility Charges	No Copay	County)	Required)* after deductible	80% after deductible	Required)* after deductible
Dhysician & Curacan's Carriage	No Copay	No Copay	70% (Precertification Required)* after deductible	80% after deductible	60% (Precertification Required)* after deductible
Physician & Surgeon's Services	No Copay	No Copay	70% (Precertification	80% after deductible	60% (Precertification
Outpatient Surgery	No Copay	\$50 Copay	Required)* after deductible	80% after deductible	Required)* after deductible
Non-certification Penalty	NA NA	NA NA	\$400 Penalty	\$400 Penalty	\$400 Penalty
Maternity		10.	\$ 100 Tollarly	\$ 100 F offally	ψ 100 T offalty
Pre & Postnatal Exams(after pregnancy has been determined)	Copay waived after 1st visit	Copay waived after 1st visit	70% after deductible	Copay waived after 1st visit	60% after deductible
,	, ,	\$100 In-Patient Copay			
Delivery	No Copay	(reimbursed by County)	70% after deductible	80% after deductible	60% after deductible
Emergency Care (Defined by Plan)					
			\$100 Copay if emergency,		\$100 Copay if emergency,
Emergency Room-Copay Waived @ Admit	\$75 Copay	\$100 Copay	otherwise 70%	\$100 Copay	otherwise 60%
Ambulance	No Copay	No Copay	No Copay	90% after deductible	90% after deductible
Equipment & Devices					
Durable Medical Equipment	No Copay (\$3500 Max)	No Copay (\$3500 Max)	Covered In-Network Only	80% after ded. (\$700 max.) 80% after \$200 ded. (\$1,000	60% (\$700 max.) 60% after \$200 ded, (\$1000
External Prosthetics & Orthotics	No Copay (\$1000 Max)	No Copay (\$1000 Max)	Covered In-Network Only	max.)	max.)
Outpatient Rehabilitation Physical, Speech, and Occupational					
Therapy Chiropractic Services	\$10 Copay	\$10 Copay	70% after deductible	\$20 Copay*	60% after deductible*
Open Access; No referral required; visit limit is per	\$10 Copay	\$10 Copay			
calendar year	20 visits	20 Visits	Covered In-Network Only	\$20 Copay**	60% after deductible**

Benefit Limit per Contract Year Ancillary Benefits	60 Visits	60 visits, in-network & out-of-network combined		*60 therapy visits, in-network & out-of-network combined ** Unlimited Visits	
Vision & Hearing Screening Other Healthcare Facilities	\$10 Copay	\$15 Copay	Covered In-Network Only	\$20 Copay	Covered In-Network Only
Skilled Nursing Facilities					
Subscriber Payment	No Copay	No Copay	70% after deductible	80%	60%
Limit per Contract Year	90 Days Combined No Copay when medically	90 Days Combined No Copay when medically	90 Days Combined 70% ded. up to 40 Days per	90 Days Combined 80% after deductible	90 Days Combined 60% after ded. up to 40 Days
Home Health Care	necessary (Unlimited)	necessary (Unlimited)	Year	(Unlimited)	per Year
Family Planning					
Sterilization					
Vasectomy	Place of Service Copay	Place of Service Copay	70% after deductible	80% after deductible	60% after deductible
Tubal Ligation	Place of Service Copay Diagnostic Services and	Place of Service Copay Diagnostic Services and	70% after deductible	80% after deductible Diagnostic Services and	60% after deductible
Infertility Treatment	Corrective Treatment Only	Corrective Treatment Only	Covered In-Network Only	Corrective Treatment Only	Covered In-Network Only
Dependent Children					
	Covered to Age 19 Unless Full				
Unmarried and legally dependant upon employee and/or spouse	Time Student and Then Covered to Age 25-(Includes Missionaries)	Covered to Age 19 Unless Full Time Student and Then Covered to Age 25-(Includes Missionaries)		Covered to Age 19 Unless Full Time Student and Then Covered to Age 25-(Includes Missionaries)	
Pharmacy Benefit	Walgreens Health Initiatives	Walgreens Health Initiatives THREE LEVEL PLAN: Generics: 25% Coinsurance		Walgreens Health Initiatives	
	THREE LEVEL PLAN:			THREE LEVEL PLAN:	
	Generics:			Generics:	
	25% Coinsurance			25% Coinsurance	
	Min Cost \$2.00, Max Cost \$10.00	Min Cost \$2.00, Max Cost \$10.00		Min Cost \$2.00, Max Cost \$10.00	
	Brand On:		nd On:	Brand On:	
	30% Coinsurance	30% Coinsurance		30% Coinsurance	
	Min Cost \$5.00, Max Cost \$25.00	Min Coat CE 00	May Coat \$25.00	Min Coat \$5.00	May Coat \$25.00
	هوري Brand Off:	Min Cost \$5.00, Max Cost \$25.00 Brand Off:		Min Cost \$5.00, Max Cost \$25.00 Brand Off:	
	30% Coinsurance	Brand Off: 30% Coinsurance		30% Coinsurance	
	Min Cost \$20.00, Max Cost	30 % Comparation		30 70 00	on surance
	\$50.00	Min Cost \$20.00, Max Cost \$50.00 Annual Out-of-Pocket Maximum		Min Cost \$20.00, Max Cost \$50.00	
	Annual Out-of-Pocket				
	Maximum			Annual Out-of-Pocket Maximum	
	\$1500 - Single/\$3,000 Family	\$1500 - Single/\$3,000 Family		\$1500 - Single/\$3,000 Family	
Behavioral Health Benefit	United Behavioral Health	United Behavioral Health		United Behavioral Health	
Vision Benefit	AVESIS Vision Plan	AVESIS Vision Plan		AVESIS Vision Plan	

Note: Lifetime Maximum and Visits per year for Out of Network Services, cross-accumulates with In-Network.

The detailed benefit summaries provide a more comprehensive summary of benefits.

Revised 01/14/03

T:/Benefits/KnowYourBenefits/plandesigns011403.xls

HealthSelect

In-Network

20 days per illness No Copay when medically necessary (Unlimited)

	<u>In-Network</u>
Standard Benefit Coverage	
Deductible	
Individual	None
Family	None
Standard Coinsurance Percentage Covered by Plan	
Out of Pocket Maximum for specific services	
Individual	
Family	
Lifetime Maximum Benefit	
Pre-existing Conditions	None
General Services	
Preventive Care	\$5 Copay
Primary Care Physician Services	\$5 Copay
Specialty Care Physician Services	\$5 Copay
Urgent Care Facility (Participating)	\$5 Copay
Out-patient Lab and X-Ray	No Copay
In-patient Coverage	
Facility Charges	No Copay
Physician & Surgeon's Services	No Copay
Outpatient Surgery	No Copay
Non-certification Penalty	NA
Maternity	
Pre & Postnatal Exams(after pregnancy has been	
determined)	Copay waived after 1st visit
Delivery	No Copay
Emergency Care (Defined by Plan)	
Emergency Room-Copay Waived @ Admit	\$50 Copay
Ambulance	No Copay
Equipment & Devices	
Durable Medical Equipment	No Copay
External Prosthetics & Orthotics	No Copay
Outpatient Rehabilitation	
Physical, Speech, and Occupational	
Therapy	\$5 Copay
Chiropractic Services	
Open Access; No referral required; visit limit is per	\$10 Copay
year	12 Visits
Maximum Therapy & Chiropractic visits combined per	60 Visits/Days
Ancillary Benefits	
Vision & Hearing Screening	\$5 Copay, \$500 per year
Other Healthcare Facilities	
Skilled Nursing Facilities	
Subscriber Payment	No Copay

Home Health Care Family Planning

Limit per Contract Year

Sterilization

Vasectomy **Tubal Ligation** Infertility Treatment

Dependent Children

Unmarried and legally dependant upon employee and/or spouse

Pharmacy Benefit

Place of Service Copay Place of Service Copay Not Covered

Covered to Age 19 Unless Full Time Student and Then Covered to Age 25-(Includes Missionaries)

HealthSelect

RETAIL:

\$5.00 Copay for Generics \$15.00 Copay for Brand MAIL ORDER: \$15 Copay for Generics \$30 Copay for Brand

90-day supply

Behavioral Health Benefit Vision Benefit

United Behavioral Health AVESIS Vision Plan

Note: Lifetime Maximum and Visits per year for Out of Network Services, cross-accumulates with In-Network. The detailed benefit summaries provide a more comprehensive summary of benefits.

Revised 11/15/02